WISCONSIN LEGISLATURE

P. O. Box 7882 Madison, WI 53707-7882

March 3, 2010

To: Senate Committee on Public Health, Senior Issues, Long-Term Care and Job Creation
Chair Tim Carpenter
Members of the Committee

From: Senator Luther Olsen
Senator Mark Miller

Re: Senate Bill 553, The Rural Healthcare Access Act

Thank you Chairman Carpenter and members of the committee for having a public hearing on Senate Bill 553, the Rural Healthcare Access Act. We appreciate your willingness to schedule this bill in your committee. As members of the State Senate who represent critical access hospitals, we believe this bill is an important bipartisan solution to protect quality health care in Wisconsin.

Although this may seem as though this bill is moving quickly, we have been working for several months to draft this bill carefully. The Wisconsin Hospital Association, Rural Wisconsin Health Cooperative, the University of Wisconsin, the Department of Health Services, Legislative Fiscal Bureau and Legislative Reference Bureau have all worked collaboratively to find a solution to protect our critical access hospitals.

As you will hear from many others today critical access hospitals are instrumental in ensuring non-urban areas of our state have access to needed health care services. We rely on these facilities, their programs and their providers to serve our families on site and sometimes in their homes. Critical access hospitals are also an employer and essential to many communities livelihood.

This bill creates an assessment, specifically, on critical access hospitals, which in turn allows the state to draw down additional federal dollars. These dollars will go back to the critical access hospitals, provide additional funding for our rural residency programs and health care provider loan programs, and generate additional dollars for the MA Trust Fund.

We believe this is an important way we can support our critical access hospitals and our communities, who have asked for and support this legislation.

KATHLEEN VINEHOUT
STATE SENATOR

Testimony on SB 553
Senate Committee on Public Health, Senior Issues, Long-term Care and Job Creation
Wednesday, March 3, 2010

Critical Access Hospitals are a vital part of our state's rural health care system. Statewide, rural communities are served by 59 Critical Access Hospitals; seven of them are in the 31st Senate District.

These hospitals are the lifeline for rural people and their communities. From the injured farmer, to the young family with a new baby, to the person with chronic disease, to the frail aging resident, health care provided in their rural community can literally mean the difference between life and death. Someone experiencing life threatening conditions may not survive a trip to urban medical center over an hour away.

In addition to being the backbone of the rural health care system; they are an essential part of the rural economy. Hospitals in my Senate District provide employment for over 1,000 people and their wages help drive the local economy. Rural hospitals purchase millions of dollars in goods and services which also help create jobs.

Critical Access Hospitals face great pressures and the recession has only increased that pressure. Many of these hospitals see a higher percentage of Medicare/Medicaid patients as well as those who are under- or uninsured. As a result they are struggling with increased charity care and bad debt.

I met with representatives of nearly all of my Critical Access Hospitals and they shared with me the incredible strain of uncompensated care and declining government reimbursement. They have implemented cost saving measures, including wage freezes and benefit reductions at the same time they are struggling with chronic shortages of health care professionals.

The DHS proposal will permanently change the Critical Access Hospital reimbursement from 100% to 90% of cost. For the hospitals in my Senate District the proposed cut would mean a loss of nearly $1.2 million over the next two years. My constituents cannot believe that we would allow DHS to enact a policy that will cripple the rural health care system.

The cut proposed by DHS would exacerbate the already tenuous financial health of the Critical Access Hospitals. With many running on the narrowest financial margin, the real possibility of closure exists and once lost, these hospitals will be nearly impossible to replace. Rural areas of Wisconsin will be left with no immediate access to vital health care services.

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Already my home county, Buffalo, has no hospital. The only hospital, located in Mondovi, closed many years ago. My neighbors and I in Alma must travel to Minnesota or drive over an hour to seek care in surrounding counties. I can't imagine what would happen if the Critical Access Hospitals in those counties were to disappear.

The bill before you provides us a carefully crafted solution. It brings in additional federal dollars to prevent the proposed 10% cut; to strengthen our rural health care system by increasing reimbursement to Critical Access Hospitals, and by providing funding to help attract physicians, advanced practice nurses and other essential health care professionals.

I urge the committee to support our rural health care system by supporting SB 553.

Thank you.

WISCONSIN HOSPITAL ASSOCIATION, INC.

March 3, 2010

TO: Members, Senate Committee on Public Health, Senior Issues, Long Term Care and Job Creation

FROM: Eric Borgerding, Executive Vice President

SUBJECT: Comments in Support of SB 553 – The Rural Healthcare Access Act

The Wisconsin Hospital Association represents over 130 non-profit hospitals across the state, including all of Wisconsin's fifty-nine small, rural Critical Access Hospitals (CAHs). On behalf of those members, we wish to thank Chairman Carpenter for both sponsoring and quickly holding a hearing on SB 553 -- the Rural Healthcare Access Act. With the 2009-10 session winding down, swift action is needed to avert damaging cuts to rural health care and we appreciate your commitment to acting on this legislation expeditiously. And thank you Committee members Coggs, Schultz and Vinehout for co-sponsoring SB 553.

We also want to express our gratitude to the authors of SB 553, Senators Miller and Olsen and Representatives Hraychuck and Ballweg and to the forty-one total sponsors of this important legislation. This impressive bipartisan show of support is a clear indication of the important role rural hospitals play in their communities across Wisconsin.

How Did We Get Here?

The 2009-11 state budget included roughly $630 million in all funds cuts to Medicaid. These cuts were unspecified in the budget act and it fell to the Department of Health Services (DHS) to implement the reductions. Through a process involving multiple stakeholders, DHS focused on finding hundreds of millions in savings largely through reducing Medicaid utilization. Reducing eligibility and benefits were not options and avoiding provider reimbursement cuts was a goal.

It is difficult to find cuts of this magnitude within such tight parameters, yet WHA provided several options that saved millions by both reducing utilization and improving quality. Additionally, urban hospitals had recently contributed over $300 million to the 2009-11 Medicaid budget through the hospital assessment enacted earlier in the 2009. At that time, CAHs were not included in the assessment.

While some of WHA's ideas were adopted, others were set aside for future consideration. We appreciate the Department's efforts to seek input from key stakeholders; however, one proposal did move forward that WHA strongly opposes - a ten-percent cut in Medicaid payments to CAHs. The cut will reduce Medicaid reimbursement to these rural hospitals by approximately $15 million (all funds) over the remainder of the biennium, and by even more in future years.

From Sturgeon Bay to Superior, from Boscobel to Waupaca, there are 59 CAHs located in 29 Assembly and 17 Senate districts across Wisconsin. They serve large geographic areas with round-the-clock care and employ thousands of people in rural areas. The cuts will have a damaging impact on many of these communities.

While CAHs typically operate on lower patient volumes, over half their patients are enrolled in government programs (Medicare and Medicaid). Due to the recession, they continue struggling with growing Medicaid losses, skyrocketing charity care and bad debt. In 2008, half of the state's CAHs reported operating margins that were

either marginally positive or in the red. Many have already faced the necessary realities of scaling back employment and reducing services. A ten-percent reduction in Medicaid payments simply could not come at a worse time.

Cuts Will Impact Rural Healthcare and Rural Economies

Though the cuts have now been in effect for just two months, the long-term impact will be severe. In February, WHA surveyed CAHs statewide to gauge to potential impact of the cuts. Thirty-seven CAHs (67%) responded. The findings are troubling, especially during a recession. When we asked CAH leaders how they will cope with the ten-percent reduction:

- Fifty-five percent say they will eliminate, modify or delay capital spending, including renovations and other projects that employ people in the construction trades, an industry already hit hard by the recession.

- Twenty-four percent said they would be forced to freeze hiring. This is particularly alarming given that hospitals are some of the largest, and often best, employers in rural communities.
  Other actions include scaling back hours and overtime, reducing FTEs and suspending retirement contributions.

- Preserving access to patient care is clearly a priority, with just nine percent responding they would have to eliminate some existing services. However nearly half (45%) said they might be forced to scale back services. In rural areas, CAHs are more than just 24/7/365 hospital care. Many subsidize other community health care services including nursing homes, hospice, home health, behavioral health and assisted living.

What is *The Rural Healthcare Access Act* (SB 553) and Why is it Needed?

Given the condition of the economy and the impact Medicaid cuts will have on rural health care and jobs, we simply could not let this cut stand. Though disappointed with their decision to implement an across-the-board cut to rural hospitals, we immediately began a dialogue with DHS about potential alternatives. As a result, DHS delayed the cut for six months and WHA collaborated with the Rural Wisconsin Health Cooperative to develop a solution.

With the cuts scheduled to begin January 1, 2010, we convened a joint member task force with the goal of finding a solution-- quickly. The task force was comprised of CAH leaders from across the state and chaired by Ed Harding, CEO of Columbus Community Hospital. The group met three times during October and November and considered various options, ranging from doing nothing and letting the cuts take their toll to fighting the cuts/pushing them off to someone else. Neither were acceptable solutions.
Developed with the technical assistance of DHS and legislative staff, and receiving the unanimous support of the WHA/RWHC task force, we believe ***The Rural Healthcare Access Act*** **(SB 553) is that solution.**

SB 553 is modeled after the successful program now in place for all other Wisconsin hospitals. It allows CAHs to pool their dollars to prevent crippling cuts and preserve "critical access" to hospital and hospital-supported health care in rural communities. Specifically, SB 553 imposes a modest assessment (approximately 1.6%) on each CAH's gross patient revenues that will generate roughly $10.6 million in FY2011. The revenue will be used in the following ways (see attached chart):

- About $3.6 million will be used **to restore the 10% cut in FY11**, thereby preventing devastating and permanent cuts but also *keeping* roughly $7 million in matching federal Medicaid dollars that would otherwise be given up.

- Approximately $6 million will be matched with additional federal Medicaid dollars and used to improve Medicaid payments to CAHs, thereby strengthening, rather than cutting, the rural health care safety net.

- The remaining $1 million will fund additional rural residencies for graduating physicians and increase loan forgiveness programs for health care professionals choosing to practice in rural Wisconsin. Both of these provisions will help address chronic rural health care workforce shortages projected to become much worse in the future.

The Rural Healthcare Access Act is being *requested and proposed by hospitals* to preserve access to health care in Wisconsin's rural communities. WHA strongly supports SB 553 and believes it is a special opportunity to actually strengthen the rural healthcare safety net at time of unprecedented strain.

Key Features of the Rural Healthcare Access Act – AB 770/SB 553

Restores the cuts to rural hospitals beginning in FY11, using no GPR. Strengthens rural health care by capturing an additional $11.2 million in federal MA dollars and using those funds to increase Medicaid payments to Critical Access Hospitals (CAHs), again using no GPR. To accomplish this, the bill does the following:

1. Implements an assessment on CAHs that is structured like the current hospital assessment:

- DHS would base the assessment amount on each CAH's gross inpatient revenue.
- Revenue base would be limited to hospital services.
- The approximately 1.6 percent assessments would be due quarterly beginning in the second year of the biennium.
- The quarterly payments to the State would follow the rate increases, maintaining a positive cash flow for the CAHs.
- DHS could delay payments for financially challenged CAHs.

2. Ensures that the CAH assessment has the same safeguards as the current hospital assessment:

- Creates a separate segregated fund.
- Creates a separate appropriation.
- Amount of funding available for rate increase would be a specified in statute (product of a formula in which the assessment is 61.68 percent of the payment increase).
- HMOs would be contractually required to pass through assessment payments.
- Monthly supplemental payments from HMOs to each CAH would be based on the CAH's proportional share of the HMO's CAH inpatient discharges and outpatient visits.
- DHS would verify that the HMO payments to CAHs are correct based on HMO encounter data and other information.
- The CAH payments would be part of the annual DHS reports to the Joint Finance Committee confirming hospitals and CAH payments.
- If assessment revenue cannot be used as intended, it would be returned to the CAHs, as would a proportionate amount of the revenue that is not used for CAH funding.

Increase the number of physicians, dentists, advanced practice nurses and other important health professionals in underserved rural areas by providing funding for rural residencies and loan forgiveness, again using no GPR.

1. Creates a new rural physician residency assistance program:

- Background: after finishing medical school, a newly licensed physician begins what is typically a multi-year residency, during which experienced physicians provide the resident physician with specialized training.
- Bill: Using $750,000 from the CAH assessment revenue, the Wisconsin Office of Rural Health (WORH) (located within the UW's Department of Family Medicine), would work to establish and to support rural physician residency positions and rotations.

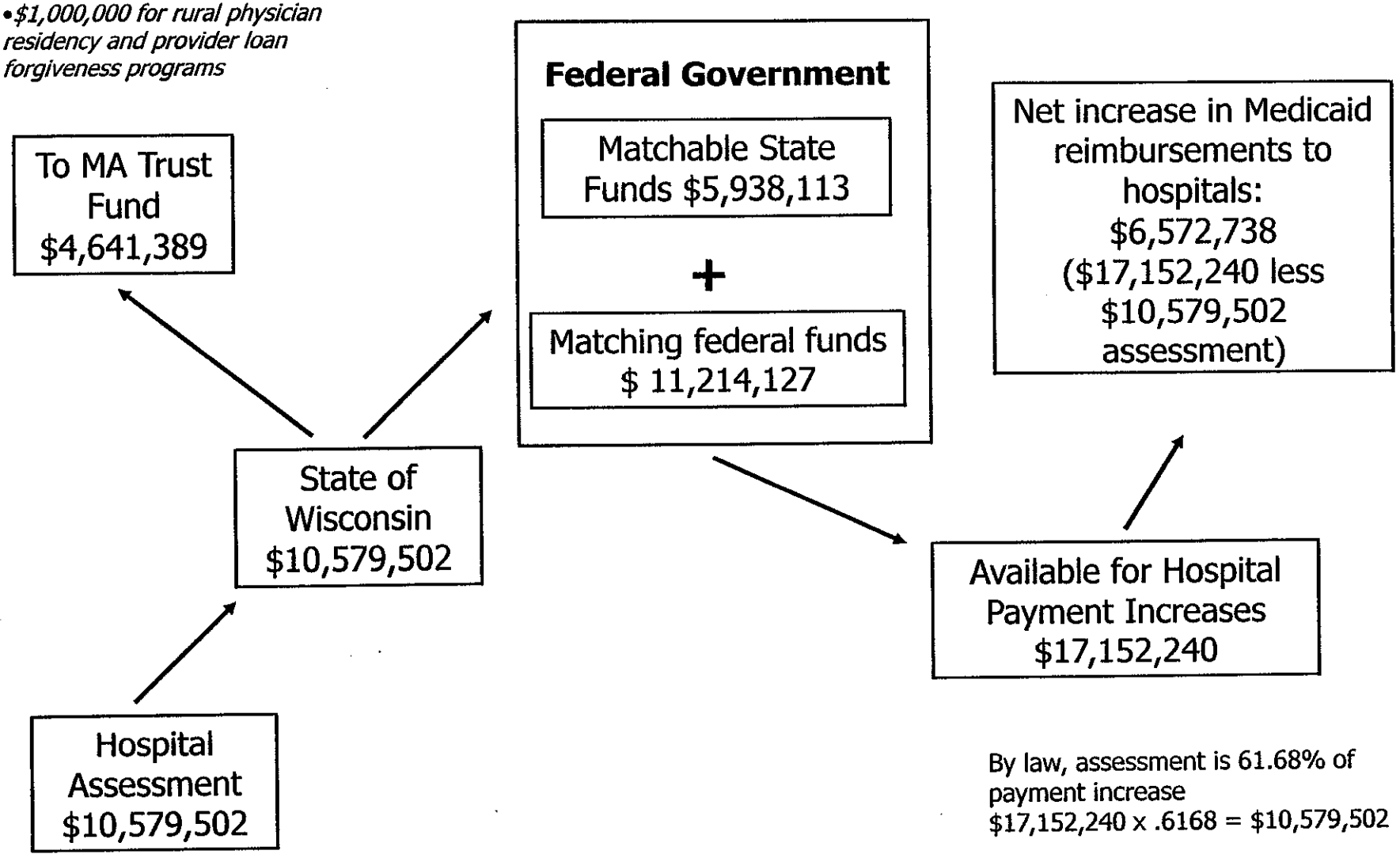
- To be eligible for the funding, a physician resident must specialize in family practice, general surgery, internal medicine, obstetrics, pediatrics, or psychiatry.
- The funded residencies and rotations must be in a hospital or clinic in a "rural area," which is a city, town, or village with a population of less than 20,000 that is at least 15 miles away from a larger city, town, or village.
- WORH would give preference to graduates of the UW School of Medicine and the Medical College of Wisconsin for the funded positions.
- The funded residency rotations must provide at least 8 weeks of rural training experience to physician residents.
- WORH would be required to submit a plan annually to the Wisconsin Hospital Association, Rural Wisconsin Health Cooperative, and the Wisconsin Medical Society for increasing the number of rural physician residency programs.
- WORH would be required to submit a report annually to the Joint Committee on Finance that demonstrates how the money has been used to increase rural residency positions and rotations.

2. Provides additional funding for health care provider education loan programs:

- The bill, using CAH assessment revenue, would increase funding by $250,000 a year for health care provider education loan forgiveness programs (beginning in SFY 2011).
- The health care provider loan forgiveness program currently receives $488,000 annually in state revenue.
- Health care providers who are eligible for the education loan forgiveness are physicians, dentists, nurse practitioners, dental hygienists, physician assistants, and certified nurse midwives.
- The eligible health care practitioners must practice for at least three years in a rural area.
- Physicians and dentists are currently eligible for loan forgiveness in the amount of $50,000.
- Nurse practitioners, physician assistants, dental hygienists, and certified nurse midwives are eligible for loan forgiveness in the amount of $25,000.
- The increased funding, in general, would be used to increase the number of health care practitioners who could have their education loans forgiven.
- With the additional funding, physicians who practice in a rural area for at least three years would be eligible for education loan forgiveness up to $100,000.

CAH Hospital Assessment Proposal – FY2011

•$3,641,389 to "backfill" rural hospital cuts in Medicaid budget
•$1,000,000 for rural physician residency and provider loan forgiveness programs



By law, assessment is 61.68% of payment increase
$17,152,240 x .6168 = $10,579,502

RWHC
Your partner. Your source.

TO: Members, Senate Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation
Senator Tim Carpenter, Chairperson

FROM: Tim Size, Executive Director
Rural Wisconsin Health Cooperative

DATE: March 3, 2010

RE: **SUPPORT** Senate Bill 553 – Rural Healthcare Access Act

The Rural Wisconsin Health Cooperative (RWHC) wants to thank you for holding a hearing on the Rural Healthcare Access Act. RWHC is a network with 35 Wisconsin hospital members that aims to provide leadership on rural health issues. RWHC works to achieve the goal that rural Wisconsin communities will be the healthiest in America.

The Rural Healthcare Access Act is a bill being proposed by the RWHC and Wisconsin Hospital Association, in response to the Department of Health Services' (DHS) ForwardHealth Rate Reform Project that called for hundreds of millions in cuts to Medicaid. The project, a response to a 2009-2011 state budget directive, included a 10% ($15 million) cut in Medicaid payments to Critical Access Hospitals (CAHs). There are 59 CAHs across rural areas in Wisconsin, 28 of which are RWHC members, serving large geographic areas with round-the-clock care and employing thousands of people in rural areas.

A permanent, across-the-board cut would have a detrimental impact on access to care in many rural communities, and the manner in which these cuts have been implemented would be a reversal of the State's longstanding payment policy for CAHs. These rural hospitals operate on lower patient volumes and have relatively higher government-paid health care recipients than their urban counterparts, so a cut in Medicaid would have a more severe impact on the necessary care they provide their communities. The hard economic times have taken their toll on CAHs too, with charity care and bad debt increasing, resulting in services and jobs having to be cut or scaled back. In 2008, half of the state's CAHs reported operating margins that were either barely positive or in the red. So, without the Rural Health Care Access Act that will be used to gain federal match dollars, many of these hospitals would be force to cut more services and jobs.

Modeled after the successful assessment now in place for Wisconsin's larger hospitals, the Rural Healthcare Access Act works by imposing an assessment (1.6%) on each hospital's revenues and using the generated dollars, through the state's Medicaid program, to capture more federal health care dollars. By pooling their dollars, CAHs will prevent crippling cuts and preserve "critical access" to hospital and hospital-supported health care in rural communities. The State's Medical Assistance Trust Fund will realize a positive fiscal impact of more than $23 million per year, or roughly a one percent gain.

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Recent times have been particularly tough on rural hospitals, working to protect their patients and community from the effect of not one storm but a plague of once in a generation storms. Think of the uncertainty on the ground around federal healthcare reform, of state budget shortfalls, of physician and healthcare workforce shortages, the effects of the global recession, and of course, H1N1. Each one of the five is a big challenge. All five at one time would cause any of us to do more than lose sleep.

Unemployment is at all time highs. But even in the recession, there are many shortages of health care professionals in rural communities. And hospitals and clinics are already scrambling as they work to prepare for even bigger shortages. Healthcare workers are mostly baby boomers. These healthcare workers are beginning to retire out of health care and increasingly, with age, into becoming patients themselves.

It is not hyperbole to say that this is the most important legislation facing CAHs in years, because the legislation will not only address a crucial funding issue, but it seeks to be prospective by addressing the impending long-term problem of physician worker shortage by providing dollars to be used to fund residency positions for graduating physicians, so they can be trained, and eventually practice, in rural areas. The Rural Healthcare Access Act provides $1 million to fund these additional residencies for graduating physicians and increase loan forgiveness programs for health care professionals choosing to practice in rural Wisconsin. Both of these provisions are investments in the future that will help address chronic health care workforce shortages projected to become much worse.

The University of Wisconsin School of Medicine and Public Health has started to be proactive in addressing the rural healthcare workforce crisis, establishing the Wisconsin Academy of Rural Medicine (WARM) that when it is at its full capacity will be producing 25 graduating physicians a year who want to practice in rural areas. However, currently Wisconsin only has three rural track residencies for them to be trained at, resulting in this new physician leaving for a rural residency in another state or not practicing in a rural area.

For several years, health care analysts and economists have been predicting massive and growing shortages of health workers in the United States. According to the Institute of Medicine publication, *Retooling for an Aging America: Building the Health Care Workforce,* the United States will need an additional 3.5 million health care providers by 2030 just to maintain the current ratio of providers to the total population. This is a 35% increase over current levels. We need to get started expanding the opportunities for rural track residencies or we will lose the benefit and promise of WARM to rural Wisconsin.

Wisconsin's rural hospitals are strongly committed to improving patient safety as we provide quality and patient-centered care. The RWHC asks the committee members to **SUPPORT** Senate Bill 553, the Rural Healthcare Access Act. The RWHC believes, now more than ever, that the challenges that Rural Wisconsin is facing on the health care front present cause for deep concern for maintain high quality and "critical access." Rural hospitals are *requesting* the Rural Healthcare Access Act to not only to preserve, but also improve rural access to health care in Wisconsin's rural communities.

Jeremy Normington CEO Moundview Memorial Hospital
608-339-8376

Carpenter

Thank you Chairman ~~Garthwaite~~ and committee members for allowing me the opportunity to speak on an issue that is already affecting the Critical Access Hospitals of our state. Thank you additionally for speed with which you are moving on this matter. Finally, I would like to thank my district ~~representative~~ senator ~~Marlin Schneider~~ for ~~his~~ her co-sponsorship of this bill.

Jule Lassa

My name is Jeremy Normington and I am privileged to serve as the CEO of Moundview Memorial Hospital in Adams-Friendship, WI. We employ approximately 150 individuals with good paying jobs, who, in turn, support our local economy by spending their hard earned money close to home. We offer inpatient medical services along with our Emergency Department and ancillary services including Rehabilitation, Laboratory, Radiology, and Surgery. We also own and operate a rural health clinic in the community that employs 3 physicians, 1 nurse practitioner and 1 physician assistant. ~~Our Medicaid Payer is currently~~ The Medicaid % Overall of Medicaid patients that we serve's currenty at 17%

I have been with Moundview for over 2 years, but I have been utilizing rural health care in Wisconsin for over 30 years. Furthermore I have ~~been~~ delivered ~~local~~ rural health care directly as a licensed Doctor of Physical Therapy, in the State of W.

I will tell you that this is my first public testimony, and even though you may sense some nerves in my tone of speech, I assure that I am speaking on a topic that I am very comfortable with. And while I will admit to asking the WHA how I am supposed to ~~address~~ formally address this committee, I can assure you that the content of this testimony is my own.

In the summer of 2009 I was notified that DHS was considering cuts in the Medicaid Program that would decrease reimbursement to the Critical Access Hospitals of our state. It was then that I came to Madison first. I came to Madison for two reasons. 1. For the people of Adams County and 2. For the Staff of Moundview Memorial Hospital.

Both of these groups had recently seen a tremendous change in the delivery of local health care. In August of 2008 Moundview Memorial Hospital realized a loss of 2.3million dollars from their FY 2008 which had ended in June. The facility had

less than 1 day of cash on hand. We were bleeding. An emergency, unsecured, line of credit from a local bank was the only thing that kept us from not making payroll ~~that month~~. The reason for this downturn was a culmination of many factors including: 1) The inability to retain health care executives and physicians 2) Declining reimbursement 3) And an unfavorable payor mix with increasing uninsured and underinsured.

By last summer, 12 months after our worst time, much work had already been accomplished. Unfortunately, the road to recovery caused the hospital to make some difficult choices that decreased access to health care services in Adams County.

In October of 2008 the Hospital's Nursing home transferred its last resident out. In December of 2008 the hospital discharged its final home health patient. And on June 30th, 2009 the hospital used its ambulance for the last time to transport an injured patient.

Jobs were also lost in the effort to save the hospital. In June of 2008 the hospital employed over 150 Full Time equivalent employees. Today we are at 112 Full Time Equivalents, a reduction in over 25% of our work force. However, these efforts allowed one of the area's largest employers to stay in business. And we had a plan!

With our financial downturn we went into technical default on our bond covenants. We were working hard to get back into compliance, but the road was long. FY 2009, which had just ended in June, showed a loss of 361K, substantially better than the 2.3 million of 2008. FY 2010 had a budgeted loss of nearly 200K, but when we looked out five years to 2014 we could see that sustained profitability was in our future.

The news of the Medicaid cuts last summer was devastating and couldn't have come at a worse time. The cuts would equate to a loss in revenue of over 100K annually for Moundview. We are a system with no more juice to squeeze. It just

isn't there. In preparation for this testimony, I labored in coming up with options for the future should these cuts continue. And I honestly don't know what to report. We have cut every service line that is not absolutely essential. We have thinned staff to a bare bones level. We have been on a 2 year wage freeze for staff, we have stopped matching our retirement plan for employees, we have called our 3 bargaining units back the table 5 separate times now for concessions. We have had to replace a Medical Doctor with a Physician Assistant because I couldn't compete with the sign on incentives totaling $80K from our larger competitors. There is simply no fat left to trim. We have had a going concern opinion for the past 2 years from our auditing firm and these reimbursement cuts may be just the thing that causes those opinions to come to fruition.

I also fear for my fellow CAH's and what they will have to endure should these cuts stay in effect. I can sympathize with how difficult it is to have your community members shop for health care locally when all they see is service after service leave their community hospital.

I can empathize with my peer rural hospital administrators who will walk with their heads down thru their local grocery store not wanting to meet eyes with the 1 in 5 members of their staff who have been laid off.

I understand the incredibly daunting task that the State is facing with its budget. And I realize that decreasing access and increasing unemployment was never an intent of the rural Medicaid cuts, but it will certainly be a result.

And that is why I became involved. I was there at the initial DHS meetings to share my thoughts and perspectives. And I was very appreciative that the Department asked us to come up with thoughts of our own. I was able to Invite Rep Schneider and Sen Lassa to Moundview where we discussed the issue. When a WHA Task Force was formed to address the concern, I volunteered without hesitation. We worked hard to come up with a solution. Ideas were shared, opinions were expressed and ultimately consensus was achieved. Consensus not only of the Task

Force Members, but consensus of Wisconsin's Critical Access Hospitals as a whole. The bill before you is the result. + it is a win-win for both the state + critical access hospitals

Without this bill, Moundview Memorial Hospital would sustain a loss in revenue of approximately 165K over the next 18 months. With this bill, the effect would be a ~~net~~ approximate break even (no loss), with an opportunity for increased reimbursement going forward.

Without this bill, I have been recruiting for 6 months and only received 1 resume for a physician candidate that I could get an interview with. With this bill, the presence of rural physicians in Wisconsin will be increased thru rural residencies and the loan repayment opportunities will also grown substantially giving the people of Adams County a greater chance to access physician care.

Moundview is in a critical time in its history. With this bill, we can start to think about increasing services, generating more revenues, and creating jobs. No company I have ever been associated with has been able to cut its way to prosperity, and Moundview is no different, but funding is essential to support the growth efforts needed.

I was discussing my testimony with my wife ~~last~~ Monday night and she made a striking comment that has stuck with me. She said, "Jeremy you are not dealing with a piece of paper here, you are dealing with a community". She is right. We are not dealing with the piece of paper that signed the Medicaid cuts into effect. We are not even dealing with the signature page that would sign this bill into law. We are dealing with Wisconsin communities, much like Adams-Friendship, who need their jobs and access to local health care.

Please vote "yes" on this bill. A "yes" vote will allow continued access to health care in otherwise under-served areas, and will protect the economic heart of our rural communities. I sincerely appreciate your allowing me to share my perspective comments and I thank you in advance for your consideration of them.

University of Wisconsin
SCHOOL OF MEDICINE
AND PUBLIC HEALTH

TO: COMMITTEE ON PUBLIC HEALTH, SENIOR ISSUES, LONG-TERM CARE and JOB CREATION

FROM: UW SCHOOL OF MEDICINE AND PUBLIC HEALTH
DR. VALERIE GILCHRIST, CHAIR, FAMILY MEDICINE
DR. BYRON CROUSE, ASSOCIATE DEAN FOR RURAL AND COMMUNITY HEALTH
LISA MARONEY, LEGISLATIVE LIAISON

DATE: MARCH 3, 2010

SUBJECT: SUPPORT SB 553

Thank you for the opportunity to provide testimony in support of Senate Bill 553 relating to the assessment on critical access hospitals. As you may already know the bill, in an effort to help alleviate the worsening physician shortage in rural areas provides for funding through two sources. We applaud and thank the Legislature for its continued efforts to improve access to healthcare in rural areas with the creation of the separate family medicine line item in the state budget dating back to the 80s and the recent funding of the WARM program.

Currently housed within the UW School of Medicine and Public Health (UWSMPH) is the Office of Rural Health which oversees the Health Professions Loan Assistance Program. SB 553 authorizes an additional $250,000 from the critical access assessment to increase the maximum payment of the loan amount from $50,000 to $100,000 for a physician who agrees to practice in a rural area.

Medical students graduate with an average debt of $130,000. Family medicine residents will make about one third less than graduating radiologists. Debt reduction supporting physicians to choose primary care and practice in rural areas is a strong move to help alleviate the shortage.

SB 553 also provides from the CAH assessment $750,000 for the Department of Family Medicine in the UWSMPH to either:

- Establish and support certain physician residency positions at hospitals or clinics located in rural areas or
- Include a minimum of an 8 week rural rotation begun after June 30, 2010 in a rural hospital or clinic

The UWSMPH is also directed to submit a plan and a yearly report on the status of the program.

Supporting rural residency training is critical to the supply of rural physicians. The strongest predictor of where physicians practice is where they train. It's a greater predictor than where they attend medical school. We are greatly appreciative of the proposed funds and think it might be helpful for the committee to understand how residency programs are established, funded and maintained.

Currently the family medicine program has 100 to 110 residents in training. After a student graduates from medical school they must complete a residency program and the length of time varies depending on their specialty. A family medicine residency program takes 3 years to complete whereas a surgery specialty can take up to 8 years. The cost per year to fund a resident is approximately $150,000. This cost includes the resident's salary, educator costs and staff costs required to comply with a broad array of verification requirements. The funding usually flows from CMS through a teaching hospital into approved and accredited residency training. Our family medicine residency programs are supported through a separate state line item in the budget. This has allowed the UW residency to fund a small number of resident experiences in rural and office sites outside of the hospitals and hospital CMS funding. The UW family medicine department has residency programs in Eau Claire, Appleton, Wausau, Baraboo and Madison. Currently Baraboo is our only rural residency program with two students. We have had more slots in the past but there was not sufficient student interest and so they were discontinued.

We hope the Wisconsin Academy of Rural Medicine (WARM), located in the UWSMPH, will generate a larger pipeline of students interested in practicing rural medicine. Now, in the third year of WARM, over 50% of these students are interested in family medicine; 22 out of 36 students. This is an important first step.

I would like to sit before you today and tell you that within a year of receiving this money we would have residency slots available but that will not be case. That's because it is a very complex process by which residency slots are established. First, CMS must issue approval for the funding of these new slots and that is not a simple undertaking. After CMS approval the new residency slots require program accreditation from the Accreditation Council of Graduate Medical Education (ACGME) and this too is quite an extensive process. Not only do training sites have to be established, but also we would need to recruit and train the requisite educators and staff. I would encourage you to view the ACGME web site for the vast list of requirements. This is not to say it's impossible but we think everyone should realize the time and effort that will be required.

The bill also allows us to create new 8 week rural rotations. This is a much more manageable task and one we could begin immediately.

Again, thank you for the opportunity to join with the state to ensure that rural Wisconsin citizens are able to access family medicine care. We hope this is helpful and I would be happy to answer questions.

JOAN BALLWEG

WISCONSIN STATE REPRESENTATIVE

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Rep.Ballweg@legis.wi.gov

41ST ASSEMBLY DISTRICT

SB 553: Critical Access Hospitals Assessment
Testimony by State Representative Joan Ballweg
Senate Committee on Public Health, Senior Issues,
Long-Term Care and Job Creation
March 3, 2010

Thank you Chair Carpenter and members for holding this hearing on Senate Bill 553.

There are folks here that can explain the technical side of the bill, Eric Borgerding from the Wisconsin Hospital Association and Tim Size of the Rural Wisconsin Health Cooperative.

I would like to talk about my personal relationship with rural Critical Access Hospitals (CAH), and how they have been part of my life. Twenty-eight years ago my oldest child was born in a CAH, by an emergency C-section. Luckily the births of my two daughters were much less eventful, but knowing access is available in our communities for those critical life events is a crucial aspect of successful patient care.

The birth of my son, was only the beginning of my relationship with CAH's, in 1998 we moved our business from Markesan to Waupun, and shortly after the relocation, I was asked to interview for the Waupun Memorial Hospital Board of Directors. I served on the board for six years, including two years as president, and it was during my tenure that Waupun Memorial researched and then applied successfully to become a Critical Access Hospital.

As Board President I saw the opportunity of the Critical Access funding model as a means to provide cost effective reliable health care service to the people of western Fond du Lac and southern Green Lake counties. In setting rates for the hospital on an annual

basis, we could keep our charges down because being paid cost on MA services is the right thing for all the patients of the community, including the private payers.

This newly proposed system is not the preferred means, CAH were promised when assessment started they would be protected. But, times and budgets change and this is a good compromise to keep good rural health call accessible in time of crisis.

My district includes three Critical Access Hospitals, and as I explained a fourth just outside the district in Waupun. Wild Rose Community Memorial, the first CAH in Wisconsin, serves Waushara County, and it is the only one in the county. Berlin Memorial Hospital opened in 1911, and has been serving Green Lake County. It also serves north-eastern Marquette County, which has no resident hospital. The third, Ripon Memorial Hospital was started in the 1920's. The building the hospital occupies is actually owned by the City of Ripon. Local communities see the value in these CAH's and consider them necessary to serve the people of their region.

Thank you for your time and consideration of this important issue for all of rural Wisconsin.

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TO:	Senator Tim Carpenter, Chairperson and members of the Senate Public Health, Senior Issues, Long-Term Care and Job Creation Committee
FROM:	Gina Dennik-Champion, RN, MSN, MSHA Executive Director, Wisconsin Nurses Association
DATE:	March 3, 2010
RE:	Support for SB 553 – Rural Healthcare Access Act

Thank you Chairperson Carpenter and members of the Senate Public Health, Senior Issues, Long-Term Care and Job Creation Committee for allowing the Wisconsin Nurses Association the opportunity to testify in support of SB 553. SB 553 addresses increasing revenues to our rural critical access hospitals and increasing loan forgiveness dollars to physicians, advanced practice nurses, dentists and other health care providers. My name is Gina Dennik-Champion, I am a RN and I am here today representing the Wisconsin Nurses Association (WNA). As the professional nursing association for any RN in Wisconsin, WNA is pleased to share our reasons for why we support SB 553.

One of WNA's goals for this legislative biennium is to support legislation that improves access to comprehensive quality health care services for all people which in turn will increase the opportunity for Wisconsin's population to maintain health and sustain a life of quality. We believe that because of their proximity to rural populations, critical access hospitals (CAH) address this WNA legislative priority. WNA views CAHs as the agencies that can assist in delivering health promotion and prevention services, focus on health care literacy issues and provide safe and coordinated chronic care to the patient. In addition, WNA views SB 553 as a strategy for increasing the supply of advanced practice nurses for these rural health communities.

WNA supports increasing the revenue to CAHs using the matching of federal Medicaid dollars from a hospital assessment as the method for addressing the cuts that CAHs experienced as a result of the state FYE 2011 budget. This method of increasing revenues to our CAHs is necessary so that the delivery of health services can continue.

WNA strongly supports the use of a portion of the CAH revenues, which is approximately $1 million dollars, to increase the supply of the rural healthcare workforce. A recent report of the Wisconsin Primary Care Office, February 2010 stated, "Wisconsin's rural areas have much more difficulty recruiting and retaining providers than urban and suburban areas. As of February 24, 2010, 55 out of 103 of the vacancies from clinic sites requesting National Health Service Corps provider loan repayment assistance (55 out of 103) were located in rural areas of the state. This means 53% of the vacancies are for rural areas, compared to about one third of the state being considered rural."

The largest portion of the $1 million dollars will be used to support rural health residencies for physicians and physician loan forgiveness. However, SB 553 includes the provision of additional loan forgiveness dollars, $25,000/nurse, to RNs who complete a Master's Degree as an Advanced Practice Nurse with a credential to practice as a either a Nurse Practitioner or Nurse Midwife. The loan forgiveness award will be provided to the NP or CNM who select to work in a rural health community for three years following graduation. By providing these additional dollars, which we realize do not cover all the costs of the education, we can hopefully increase the supply of APNs and nurse educators for our rural health care settings and academic communities.

In summary, WNA supports SB 553 because it is good for patients. SB 553 allows CAHs to continue to provide the health care and services to their population and increases the supply of physicians, advanced practice nurses and other health care professionals working in the rural health settings.

Thank you, Chairperson Carpenter for conducting this hearing. We thank you Senators Coggs, Schultz and Vinehout for your co-sponsorship. We ask that SB 553 be voted on without delay.

Thank you